

obstetricians, the authors say, must be held accountable. If this trend is to be reversed then the “blame and claim” culture should be addressed, and childbirth without fear should become a reality for women, midwives, and obstetricians alike.

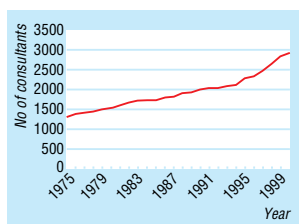
Medicalising sex damages relationships



Medicine has long been exercising its authority over sexual behaviour and in an increasingly secular society definitions of what is morally acceptable now fall to medical science. Hart and Wellings (p 896) examine the increasingly medical approach to sex, which they say ignores the social and interpersonal dynamics of relationships. They argue that the medicalisation of sex has resulted in the use of surgery and drugs to enhance sexual pleasure and that our obsession with sexual gratification increases expectations and feelings of inadequacy.

The time has come for “post-psychiatry”

Modern psychiatry encourages a biomedical model that encourages drug treatment to be seen as a panacea for multiple problems. Antidepressant prescription rates have increased alongside the number of consultants in psychiatry, which have been



rising steadily. Double (p 900) is sceptical of this approach and questions the legitimacy of psychiatric interventions for common personal and social problems. He says that psychiatry should return to a biopsychological view and recognise the uncertainties of clinical practice. Such an approach has been called “post-psychiatry,” which emphasises social and cultural contexts, places ethics before technology, and works to minimise medical control.

Is a good death now a medical death?



The development of palliative care began in the 1950s, when concerns were voiced over the apparent neglect of dying people. Research, a greater openness about terminal conditions, and a more active approach to the care of the dying person have all developed since then. The term “palliative care,” first proposed in 1974, came to symbolise this broadening orientation. Yet the charge of creeping medicalisation has, considers David Clark (p 905), now been levelled at palliative care. All doctors now face the problem of balancing technical intervention with a humanistic orientation to their dying patients.

Editor's choice

Postmodern medicine

Uwe Reinhardt, perhaps America's funniest economist, spoke some years ago of what might happen as spending on health care ate up ever larger chunks of gross domestic product. Coast to coast America would become one enormous hospital, with everyone either working in health care or being ill (or both). Reinhardt might therefore appreciate this issue on medicalisation—which discusses much the same problem but from a doctor's eye view, rather than an economist's.

Not that economists don't get a look in. Amartya Sen, an even more distinguished economist, discusses the paradox that people in America feel much less well than those in Bihar, India, though their life expectancy is much better (p 860). Indeed, a direct relation seems to exist between self reported morbidity and life expectancy. He uses this example to caution against assuming that patients' perceptions should always trump those of experts.

But the shadow that really hangs over this issue is that of Ivan Illich—author of *Medical Nemesis* and *Limits to Medicine* (reviewed, along with other old classics, on p 923). His argument, explained in the opening editorial (p 859), is that modern medicine has become a threat to health by undermining the capacity of individuals and societies to cope with death, pain, and sickness.

It's also a diversion of resources. And here the pharmaceutical industry comes in for particular criticism. Ray Moynihan and colleagues accuse it of “extending the boundaries of treatable disease to expand markets for new products” (p 886). Barbara Mintzes echoes this in her argument against direct to consumer advertising of drugs (p 908). In 1999 Americans saw an average of nine prescription drug adverts a day on television, portraying the dual message of a pill for every ill—and “an ill for every pill.” Nevertheless, Silvia Bonaccorso and Jeffrey Sturchio manage a spirited defence of “liberalised direct to consumer information” (p 910).

Indeed, this issue isn't all one sided. Shah Ebrahim asserts that the medicalisation of old age should be encouraged because treating the health problems of older people is effective and attempts to ration care on the grounds of age are unfair (p 861).

And though doctors are accused of encouraging or at least colluding in medicalisation, the alternative view that doctors are just as much its victims is also prominent. “The bad things of life: old age, death, pain, and handicap are thrust on doctors to keep families and society from facing them,” say Leonard Leibovici and Michel Lièvre (p 866). “There is a boundary beyond which medicine has only a small role.” When doctors are forced to go beyond it “they do not gain power or control: they suffer.”

That might suggest that Illich has won the argument. Indeed, David Clark, in his article on the “postmodern specialty” of palliative medicine, thinks he has (p 905). In the 1970s he says, there was a “much more unitary and optimistic view of medicine. Now the ... system is pervaded with doubt, scepticism, and mistrust.”

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